

Wisconsin Department of Regulation & Licensing

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PHYSICIAN TEMPORARY EDUCATIONAL PERMIT

AFFIDAVIT OF HOSPITAL AUTHORITY

TO BE COMPLETED BY THE ADMINISTRATOR OF THE HOSPITAL ONLY IF THE PHYSICIAN IS ENROLLED IN AN AMA OR AOA APPROVED RESIDENCY PROGRAM ACCREDITED BY ACGME IN THE STATE OF WISCONSIN.

_____, _____
(Name) (Address)
a graduate of the _____ Medical School,
(Name of School)
_____, has made application for post-graduate training in this
(Address of School)
hospital, the _____
(Name of Hospital)

_____ under the provision of a Temporary Educational Permit,
(Address of Hospital)
Permit, which will entitle him/her to receive training under our supervision for a period not to exceed one year, with renewals at the discretion of the Medical Examining Board not to exceed four additional years, upon recommendation of the administrator of this hospital.

We have examined the credentials of Doctor _____ and find that they meet the requirements of the Medical Examining Board regulations governing these permits, and are satisfactory to this Hospital. I hereby recommend that the board consider the application of Doctor _____ for a Temporary Education Permit, with his/her post-graduate training to begin in this hospital on _____, 20____.

Signature of Administrator

Name of Hospital

Print Name

Address of Hospital

Date

HOSPITAL SEAL